

which the employees participate that enhance the quality of medical care or operating efficiency of the provider and, effective October 1, 2003, do not lead to the ability to practice and begin employment in a nursing or allied health specialty.

(4) Maintenance of a medical library.

(5) Training of a patient or patient's family in the use of medical appliances or other treatments.

(6) Except as provided in paragraph (g) of this section, clinical training and classroom instruction of students enrolled in an educational program that is not operated by the provider. The following are clinical training and classroom instruction costs that are allowable as normal operating costs:

(i) Costs incurred in the clinical training of students, including the clinical training or clerkship of undergraduate medical school students that takes place in a provider.

(ii) Classroom instruction costs incurred by a provider that meet the following criteria:

(A) The provider's support does not constitute a redistribution of nonprovider costs to the provider. The support must be in addition to the costs already being incurred by the nonprovider-operated program. If the nonprovider entity reduces its costs due to receiving provider support, this reduction constitutes a redistribution of costs from an educational institution to a patient care institution and is a nonallowable provider cost.

(B) The provider receives a benefit for the support it furnishes.

(C) The cost of the provider's support is less than the cost the provider would incur were it to operate the program.

(7) Other activities that do not involve the actual operation of an approved educational program.

[66 FR 3374, Jan. 12, 2001, as amended at 66 FR 14342, Mar. 12, 2001; 68 FR 45471, Aug. 1, 2003]

§ 413.86 Direct graduate medical education payments.

(a) *Statutory basis and scope*—(1) *Basis*. This section implements section 1886(h) of the Act by establishing the methodology for Medicare payment of the cost of direct graduate medical educational activities.

(2) *Scope*. This section applies to Medicare payments to hospitals and hospital-based providers for the costs of approved residency programs in medicine, osteopathy, dentistry, and podiatry for cost reporting periods beginning on or after July 1, 1985.

(b) *Definitions*. For purposes of this section, the following definitions apply:

All or substantially all of the costs for the training program in the nonhospital setting means the residents' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the cost of teaching physicians' salaries and fringe benefits attributable to direct graduate medical education.

Approved geriatric program means a fellowship program of one or more years in length that is approved by one of the national organizations listed in § 415.152 of this chapter under that respective organization's criteria for geriatric fellowship programs.

Approved medical residency program means a program that meets one of the following criteria:

(1) Is approved by one of the national organizations listed in § 415.152 of this chapter.

(2) May count towards certification of the participant in a specialty or subspecialty listed in the current edition of either of the following publications:

(i) The Directory of Graduate Medical Education Programs published by the American Medical Association, and available from American Medical Association, Department of Directories and Publications, 515 North State Street, Chicago, Illinois 60610; or

(ii) The Annual Report and Reference Handbook published by the American Board of Medical Specialties, and available from American Board of Medical Specialties, One Rotary Center, suite 805, Evanston, Illinois 60201.

(3) Is approved by the Accreditation Council For Graduate Medical Education (ACGME) as a fellowship program in geriatric medicine.

(4) Is a program that would be accredited except for the accrediting agency's reliance upon an accreditation standard that requires an entity to perform an induced abortion or require, provide, or refer for training in

the performance of induced abortions, or make arrangements for such training, regardless of whether the standard provides exceptions or exemptions.

Base period means a cost reporting period that began on or after October 1, 1983 but before October 1, 1984.

CPI—U stands for the Consumer Price Index for All Urban Consumers as compiled by the Bureau of Labor Statistics.

Community support means funding that is provided by the community and generally includes all non-Medicare sources of funding (other than payments made for furnishing services to individual patients), including State and local government appropriations. Community support does not include grants, gifts, and endowments of the kind that are not to be offset in accordance with section 1134 of the Act.

Foreign medical graduate means a resident who is not a graduate of a medical, osteopathy, dental, or podiatry school, respectively, accredited or approved as meeting the standards necessary for accreditation by one of the following organizations:

- (1) The Liaison Committee on Medical Education of the American Medical Association.
- (2) The American Osteopathic Association.
- (3) The Commission on Dental Accreditation.
- (4) The Council on Podiatric Medical Education.

FMGEMS stands for the Foreign Medical Graduate Examination in the Medical Sciences (Part I and Part II).

FTE stands for full-time equivalent.

Medicare GME affiliated group means—

- (1) Two or more hospitals that are located in the same urban or rural area (as those terms are defined in § 412.62(f) of this subchapter) or in a contiguous area and meet the rotation requirements in paragraph (g)(7)(ii) of this section.
- (2) Two or more hospitals that are not located in the same or in a contiguous urban or rural area, but meet the rotation requirement in paragraph (g)(7)(ii) of this section, and are jointly listed—
 - (i) As the sponsor, primary clinical site or major participating institution

for one or more programs as these terms are used in the most current publication of the *Graduate Medical Education Directory*; or

- (ii) As the sponsor or is listed under “affiliations and outside rotations” for one or more programs in operation in *Opportunities, Directory of Osteopathic Postdoctoral Education Programs*.

- (3) Two or more hospitals that are under common ownership and, effective for all Medicare GME affiliation agreements beginning July 1, 2003, meet the rotation requirement in paragraph (g)(7)(ii) of this section.

Medicare GME affiliation agreement means a written, signed, and dated agreement by responsible representatives of each respective hospital in a Medicare GME affiliated group, as defined in this section, that specifies—

- (1) The term of the Medicare GME affiliation agreement (which, at a minimum is one year), beginning on July 1 of a year;
- (2) Each participating hospital's direct and indirect GME FTE caps in effect prior to the Medicare GME affiliation;
- (3) The total adjustment to each hospital's FTE caps in each year that the Medicare GME affiliation agreement is in effect, for both direct GME and IME, that reflects a positive adjustment to one hospital's direct and indirect FTE caps that is offset by a negative adjustment to the other hospital's (or hospitals') direct and indirect FTE caps of at least the same amount;
- (4) The adjustment to each participating hospital's FTE counts resulting from the FTE resident's (or residents') participation in a shared rotational arrangement at each hospital participating in the Medicare GME affiliated group for each year the Medicare GME affiliation agreement is in effect. This adjustment to each participating hospital's FTE count is also reflected in the total adjustment to each hospital's FTE caps (in accordance with paragraph (3) of this definition); and
- (5) The names of the participating hospitals and their Medicare provider numbers.

Medicare patient load means, with respect to a hospital's cost reporting period, the total number of hospital inpatient days during the cost reporting period that are attributable to patients for whom payment is made under Medicare Part A divided by total hospital inpatient days. In calculating inpatient days, inpatient days in any distinct part of the hospital furnishing a hospital level of care are included and nursery days are excluded.

Primary care resident is a resident enrolled in an approved medical residency training program in family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine or osteopathic general practice.

Redistribution of costs occurs when a hospital counts FTE residents in medical residency programs and the costs of the program had previously been incurred by an educational institution.

Resident means an intern, resident, or fellow who participates in an approved medical residency program, including programs in osteopathy, dentistry, and podiatry, as required in order to become certified by the appropriate specialty board.

Rural track FTE limitation means the maximum number of residents (as specified in paragraph (g)(12) of this section) training in a rural track residency program that an urban hospital may include in its FTE count and that is in addition to the number of FTE residents already included in the hospital's FTE cap.

Rural track or integrated rural track means an approved medical residency training program established by an urban hospital in which residents train for a portion of the program at the urban hospital and then rotate for a portion of the program to a rural hospital(s) or a rural nonhospital site(s).

Shared rotational arrangement means a residency training program under which a resident(s) participates in training at two or more hospitals in that program.

(c) *Payment for graduate medical education costs—General rule.* Beginning with cost reporting periods starting on or after July 1, 1985, hospitals, including hospital-based providers, are paid for the costs of approved graduate med-

ical education programs as described in paragraph (d) through (h) of this section.

(d) *Calculating payment for graduate medical education costs.* A hospital's Medicare payment for the costs of an approved residency program is calculated as follows:

(1) *Step one.* The hospital's updated per resident amount (as determined under paragraph (e) of this section) is multiplied by the actual number of FTE residents (as determined under paragraph (g) of this section). This result is the aggregate approved amount for the cost reporting period.

(2) *Step two.* The product derived in step one is multiplied by the hospital's Medicare patient load.

(3) *Step Three.* For portions of cost reporting periods occurring on or after January 1, 1998, the product derived in step one is multiplied by the proportion of the hospital's inpatient days attributable to individuals who are enrolled under a risk-sharing contract with an eligible organization under section 1876 of the Act and who are entitled to Medicare Part A or with a Medicare+Choice organization under Title XVIII, Part C of the Act. This amount is multiplied by an applicable payment percentage equal to—

- (i) 20 percent for 1998;
- (ii) 40 percent for 1999;
- (iii) 60 percent in 2000;
- (iv) 80 percent in 2001; and
- (v) 100 percent in 2002 and subsequent years.

(4) *Step four.* Effective for portions of cost reporting periods occurring on or after January 1, 2000, the product derived from step three is reduced by a percentage equal to the ratio of the Medicare+Choice nursing and allied health payment "pool" for the current calendar year as described at §413.87(f), to the projected total Medicare+Choice direct GME payments made to all hospitals for the current calendar year.

(5) *Step five.* (i) For portions of cost reporting periods beginning on or after January 1, 1998 and before January 1, 2000, add steps two and three.

(ii) Effective for portions of cost reporting periods beginning on or after January 1, 2000, add the results of steps two and four.

(6) *Step six.* The product derived in step two is apportioned between Part A and Part B of Medicare based on the ratio of Medicare's share of reasonable costs excluding graduate medical education costs attributable to each part as determined through the Medicare cost report.

(e) *Determining per resident amounts for the base period—*(1) *For the base period.* (i) Except as provided in paragraph (e)(4) of this section, the intermediary determines a base-period per resident amount for each hospital as follows:

(A) Determine the allowable graduate medical education costs for the cost reporting period beginning on or after October 1, 1983 but before October 1, 1984. In determining these costs, graduate medical education costs allocated to the nursery cost center, research and other nonreimbursable cost centers, and hospital-based providers that are not participating in Medicare are excluded and graduate medical education costs allocated to distinct-part hospital units and hospital-based providers that participate in Medicare are included.

(B) Divide the costs calculated in paragraph (e)(1)(i)(A) of this section by the average number of FTE residents working in all areas of the hospital complex (including those areas whose costs were excluded under paragraph (e)(1)(i)(A) of this section) for its cost reporting period beginning on or after October 1, 1983 but before October 1, 1984.

(ii) In determining the base-period per resident amount under paragraph (e)(1)(i) of this section, the intermediary—

(A) Verifies the hospital's base-period graduate medical education costs and the hospital's average number of FTE residents;

(B) Excludes from the base-period graduate medical education costs any nonallowable or misclassified costs, including those previously allowed under § 412.113(b)(3) of this chapter; and

(C) Upon a hospital's request, includes graduate medical education costs that were misclassified as operating costs during the hospital's prospective payment base year and were not allowable under § 412.113(b)(3) of

this chapter during the graduate medical education base period. These costs may be included only if the hospital requests an adjustment of its prospective payment hospital-specific rate or target amount as described in paragraph (k)(1) of this section.

(iii) If the hospital's cost report for its GME base period is no longer subject to reopening under § 405.1885 of this chapter, the intermediary may modify the hospital's base-period costs solely for purposes of computing the per resident amount.

(iv) If the intermediary modifies a hospital's base-period graduate medical education costs as described in paragraph (e)(1)(ii)(B) of this section, the hospital may request an adjustment of its prospective payment hospital-specific rate or target amount as described in paragraph (k)(1) of this section.

(v) The intermediary notifies each hospital that either had direct graduate medical education costs or received indirect education payment in its cost reporting period beginning on or after October 1, 1984 and before October 1, 1985 of its base-period average per resident amount. A hospital may appeal this amount within 180 days of the date of that notice.

(2) *For cost reporting periods beginning on or after July 1, 1985 and before July 1, 1986.* For cost reporting periods beginning on or after July 1, 1985 and before July 1, 1986, a hospital's base-period per resident amount is adjusted as follows:

(i) If a hospital's base period began on or after October 1, 1983 and before July 1, 1984, the amount is adjusted by the percentage change in the CPI-U that occurred between the hospital's base period and the first cost reporting period to which the provisions of this section apply. The adjusted amount is then increased by one percent.

(ii) If a hospital's base period began on or after July 1, 1984 and before October 1, 1984, the amount is increased by one percent.

(3) *For cost reporting periods beginning on or after July 1, 1986.* Subject to the provisions of paragraph (e)(4) of this section, for cost reporting periods beginning on or after July 1, 1986, a hospital's base-period per resident amount is adjusted as follows:

(i) Except as provided in paragraph (e)(3)(ii) of this section, each hospital's per resident amount for the previous cost reporting is adjusted by the projected change in the CPI-U for the 12-month cost reporting period. This adjustment is subject to revision during the settlement of the cost report to reflect actual changes in the CPI-U that occurred during the cost reporting period.

(ii) For cost reporting periods beginning on or after October 1, 1993 through September 30, 1995, each hospital's per resident amount for the previous cost reporting period will not be adjusted for any resident FTEs who are not either a primary care resident or an obstetrics and gynecology resident.

(4) *For cost reporting periods beginning on or after October 1, 2000 and ending on or before September 30, 2005.* For cost reporting periods beginning on or after October 1, 2000 and ending on or before September 30, 2005, a hospital's per resident amount for each fiscal year is adjusted in accordance with the following provisions:

(i) *General provisions.* For purposes of §413.86(e)(4)—

(A) *Weighted average per resident amount.* The weighted average per resident amount is established as follows:

(1) Using data from hospitals' cost reporting periods ending during FY 1997, CMS calculates each hospital's single per resident amount by adding each hospital's primary care and non-primary care per resident amounts, weighted by its respective FTEs, and dividing by the sum of the FTEs for primary care and non-primary care residents.

(2) Each hospital's single per resident amount calculated under paragraph (e)(4)(i)(A)(1) of this section is standardized by the 1999 geographic adjustment factor for the physician fee schedule area (as determined under §414.26 of this chapter) in which the hospital is located.

(3) CMS calculates an average of all hospitals' standardized per resident amounts that are determined under paragraph (e)(4)(i)(A)(2) of this section. The resulting amount is the weighted average per resident amount.

(B) *Primary care/obstetrics and gynecology and non-primary care per resident*

amounts. A hospital's per resident amount is an amount inclusive of any CPI-U adjustments that the hospital may have received since the hospital's base year, including any CPI-U adjustments the hospital may have received because the hospital trains primary care/obstetrics and gynecology residents and non-primary care residents as specified under paragraph (e)(3)(ii) of this section.

(ii) *Adjustment beginning in FY 2001 and ending in FY 2005.* For cost reporting periods beginning on or after October 1, 2000 and ending on or before September 30, 2005, a hospital's per resident amount is adjusted in accordance with paragraphs (e)(4)(ii)(A) through (e)(4)(ii)(C) of this section, in that order:

(A) *Updating the weighted average per resident amount for inflation.* The weighted average per resident amount (as determined under paragraph (e)(4)(i)(A) of this section) is updated by the estimated percentage increase in the CPI-U during the period beginning with the month that represents the midpoint of the cost reporting periods ending during FY 1997 (that is, October 1, 1996) and ending with the midpoint of the hospital's cost reporting period that begins in FY 2001.

(B) *Adjusting for locality.* The updated weighted average per resident amount determined under paragraph (e)(4)(ii)(A) of this section (the national average per resident amount) is adjusted for the locality of each hospital by multiplying the national average per resident amount by the 1999 geographic adjustment factor for the physician Fee schedule area in which each hospital is located, established in accordance with §414.26 of this subchapter.

(C) *Determining necessary revisions to the per resident amount.* The locality-adjusted national average per resident amount, as calculated in accordance with paragraph (e)(4)(ii)(B) of this section, is compared to the hospital's per resident amount is revised, if appropriate, according to the following three categories:

(1) *Floor.* (i) For cost reporting periods beginning on or after October 1, 2000, and before October 1, 2001, if the hospital's per resident amount would

otherwise be less than 70 percent of the locality-adjusted national average per resident amount for FY 2001 (as determined under paragraph (e)(4)(ii)(B) of this section), the per resident amount is equal to 70 percent of the locality-adjusted national average per resident amount for FY 2001.

(ii) For cost reporting periods beginning on or after October 1, 2001, and before October 1, 2002, if the hospital's per resident amount would otherwise be less than 85 percent of the locality-adjusted national average per resident amount for FY 2002 (as determined under paragraph (e)(4)(ii)(B) of this section), the per resident amount is equal to 85 percent of the locality-adjusted national average per resident amount for FY 2002.

(iii) For subsequent cost reporting periods beginning on or after October 1, 2002, the hospital's per resident amount is updated using the methodology specified under paragraph (e)(3)(i) of this section.

(2) *Ceiling.* If the hospital's per resident amount is greater than 140 percent of the locality-adjusted national average per resident amount, the per resident amount is adjusted as follows for FY 2001 through FY 2005:

(i) *FY 2001.* For cost reporting periods beginning on or after October 1, 2000 and on or before September 30, 2001, if the hospital's FY 2000 per resident amount exceeds 140 percent of the FY 2001 locality-adjusted national average per resident amount (as calculated under paragraph (e)(4)(ii)(B) of this section), then, subject to the provision stated in paragraph (e)(4)(ii)(C)(2)(iv) of this section, the hospital's per resident amount is frozen at the FY 2000 per resident amount and is not updated for FY 2001 by the CPI-U factor.

(ii) *FY 2002.* For cost reporting periods beginning on or after October 1, 2001 and on or before September 30, 2002, if the hospital's FY 2001 per resident amount exceeds 140 percent of the FY 2002 locality-adjusted national average per resident amount, then, subject to the provision stated in paragraph (e)(4)(ii)(C)(2)(iv) of this section, the hospital's per resident amount is frozen at the FY 2001 per resident amount and is not updated for FY 2002 by the CPI-U factor.

(iii) *FY 2003 through FY 2005.* For cost reporting periods beginning on or after October 1, 2002 and on or before September 30, 2005, if the hospital's per resident amount for the previous cost reporting period is greater than 140 percent of the locality-adjusted national average per resident amount for that same previous cost reporting period (for example, for cost reporting periods beginning in FY 2003, compare the hospital's per resident amount from the FY 2002 cost report to the hospital's locality-adjusted national average per resident amount from FY 2002), then, subject to the provision stated in paragraph (e)(4)(ii)(C)(2)(iv) of this section, the hospital's per resident amount is adjusted using the methodology specified in paragraph (e)(3)(i) of this section, except that the CPI-U applied for a 12-month period is reduced (but not below zero) by 2 percentage points.

(iv) *General rule for hospitals that exceed the ceiling.* For cost reporting periods beginning on or after October 1, 2000 and on or before September 30, 2005, if a hospital's per resident amount exceeds 140 percent of the hospital's locality-adjusted national average per resident amount and it is adjusted under any of the criteria (e)(4)(ii)(C)(2)(i) through (iii) of this section, the current year per resident amount cannot be reduced below 140 percent of the locality-adjusted national average per resident amount.

(3) *Per resident amounts greater than or equal to the floor and less than or equal to the ceiling.* For cost reporting periods beginning on or after October 1, 2000 and on or before September 30, 2005, if a hospital's per resident amount is greater than or equal to 70 percent and less than or equal to 140 percent of the hospital's locality-adjusted national average per resident amount for each respective fiscal year, the hospital's per resident amount is updated using the methodology specified in paragraph (e)(3)(i) of this section.

(5) *Exceptions—(i) Base period for certain hospitals.* If a hospital did not have any approved medical residency training programs or did not participate in Medicare during the base period, but either condition changes in a cost reporting period beginning on or after

July 1, 1985, the intermediary establishes a per resident amount for the hospital using the information from the first cost reporting period during which the hospital participates in Medicare and the residents are on duty during the first month of that period. Any graduate medical education program costs incurred by the hospital before that cost reporting period are reimbursed on a reasonable cost basis. The per resident amount is based on the lower of the amount specified in paragraph (e)(5)(i)(A) or in paragraph (e)(5)(i)(B) of this section, subject to the provisions of paragraph (e)(5)(i)(C) of this section.

(A) The hospital's actual costs, incurred in connection with the graduate medical education program for the hospital's first cost reporting period in which residents were on duty during the first month of the cost reporting period.

(B) Except as specified in paragraph (e)(5)(i)(C) of this section—

(1) For base periods that begin before October 1, 2002, the updated weighted mean value of per resident amounts of all hospitals located in the same geographic wage area, as that term is used in the prospective payment system under part 412 of this chapter.

(2) For base periods beginning on or after October 1, 2002, the updated weighted mean value of per resident amounts of all hospitals located in the same geographic wage area is calculated using all per resident amounts (including primary care and obstetrics and gynecology and nonprimary care) and FTE resident counts from the most recently settled cost reports of those teaching hospitals.

(C) If, under paragraph (e)(5)(i)(B)(1) or (e)(5)(i)(B)(2) of this section, there are fewer than three existing teaching hospitals with per resident amounts that can be used to calculate the weighted mean value per resident amount, for base periods beginning on or after October 1, 1997, the per resident amount equals the updated weighted mean value of per resident amounts of all hospitals located in the same census region as that term is used in §412.62(f)(1)(i) of this chapter.

(ii) *Short or long base-period cost reporting periods.* If a hospital's base-pe-

riod cost reporting period reflects graduate medical education costs for a period that is shorter than 50 weeks or longer than 54 weeks, the intermediary converts the allowable costs for the base period into a daily figure. The daily figure is then multiplied by 365 or 366, as appropriate, to derive the approved per resident amount for a 12-month base-period cost reporting period. If a hospital has two cost reporting periods beginning in the base period, the later period serves as the base-period cost reporting period.

(iii) *Short or long cost reporting periods beginning on or after July 1, 1985.* If a hospital's cost reporting period is shorter than 50 weeks or longer than 54 weeks, the hospital's intermediary should contact CMS Central Office to receive a special CPI-U adjustment factor.

(f) *Determining the total number of FTE residents.* Subject to the weighting factors in paragraphs (g) and (h) of this section, and subject to the provisions of paragraph (i) of this section, the count of FTE residents is determined as follows:

(1) Residents in an approved program working in all areas of the hospital complex may be counted.

(2) No individual may be counted as more than one FTE. A hospital cannot claim the time spent by residents training at another hospital. Except as provided in paragraphs (f)(3) and (f)(4) of this section, if a resident spends time in more than one hospital or in a nonprovider setting, the resident counts as partial FTE based on the proportion of time worked at the hospital to the total time worked. A part-time resident counts as a partial FTE based on the proportion of allowable time worked compared to the total time necessary to fill a full-time internship or residency slot.

(3) On or after July 1, 1987 and for portions of cost reporting periods occurring before January 1, 1999, the time residents spend in nonprovider settings such as freestanding clinics, nursing homes, and physicians' offices in connection with approved programs is not excluded in determining the number of FTE residents in the calculation of a hospital's resident count if the following conditions are met—

(i) The resident spends his or her time in patient care activities.

(ii) There is a written agreement between the hospital and the outside entity that states that the resident's compensation for training time spent outside of the hospital setting is to be paid by the hospital.

(4) For portions of cost reporting periods occurring on or after January 1, 1999, the time residents spend in non-provider settings such as freestanding clinics, nursing homes, and physicians' offices in connection with approved programs may be included in determining the number of FTE residents in the calculation of a hospital's resident count if the following conditions are met—

(i) The resident spends his or her time in patient care activities.

(ii) The written agreement between the hospital and the nonhospital site must indicate that the hospital will incur the cost of the resident's salary and fringe benefits while the resident is training in the nonhospital site and the hospital is providing reasonable compensation to the nonhospital site for supervisory teaching activities. The agreement must indicate the compensation the hospital is providing to the nonhospital site for supervisory teaching activities.

(iii) The hospital must incur all or substantially all of the costs for the training program in the nonhospital setting in accordance with the definition in paragraph (b) of this section.

(iv) The hospital is subject to the principles of community support and redistribution of costs as specified in the provisions of paragraph (i) of this section.

(g) *Determining the weighted number of FTE residents.* Subject to the provisions in paragraph (h) of this section, CMS determines a hospital's number of FTE residents by applying a weighting factor to each resident and then summing the resulting numbers that represent each resident. The weighting factor is determined as follows:

(1) Generally, for purposes of this section, effective July 1, 1995, an initial residency period is defined as the minimum number of years required for board eligibility. Prior to July 1, 1995, the initial residency period equals the

minimum number of years required for board eligibility in a specialty or subspecialty plus 1 year. An initial residency period may not exceed 5 years in order to be counted toward determining FTE status except in the case of fellows in an approved geriatric program whose initial residency period may last up to 2 additional years. Effective July 1, 2000, for residency programs that began before, on, or after November 29, 1999, the period of board eligibility and the initial residency period for a resident in an approved child neurology program is the period of board eligibility for pediatrics plus 2 years. Effective August 10, 1993, residents or fellows in an approved preventive medicine residency or fellowship program also may be counted as a full FTE resident for up to 2 additional years beyond the initial residency period limitations. For combined residency programs, an initial residency period is defined as the time required for individual certification in the longer of the programs. If the resident is enrolled in a combined medical residency training program in which all of the individual programs (that are combined) are for training primary care residents (as defined in paragraph (b) of this section) or obstetrics and gynecology residents, the initial residency period is the time required for individual certification in the longer of the programs plus 1 year.

(i) For residency programs other than those specified in paragraphs (g)(1)(ii) through (g)(1)(iv) of this section, the initial residency period is the minimum number of years of formal training necessary to satisfy the requirements for initial board eligibility in the particular specialty for which the resident is training, as specified in the most recently published edition of the Graduate Medical Education Directory.

(ii) For residency programs in osteopathy, dentistry, and podiatry, the minimum requirement for certification in a specialty or subspecialty is the minimum number of years of formal training necessary to satisfy the requirements of the appropriate approving body listed in § 415.152 of this chapter.

(iii) For residency programs in geriatric medicine, accredited by the appropriate approving body listed in 415.152 of this chapter, these programs are considered approved programs on the later of—

(A) The starting date of the program within a hospital; or

(B) The hospital's cost reporting period beginning on or after July 1, 1985.

(iv) The time spent in residency programs that do not lead to certification in a specialty or subspecialty, but that otherwise meet the definition of approved programs, as described in paragraph (b) of this section, is counted toward the initial residency period limitation.

(2) If the resident is in an initial residency period, the weighting factor is one.

(3) If the resident is not in an initial residency period, the weighting factor is 1.00 during the period beginning on or after July 1, 1985 and before July 1, 1986, .75 during the period beginning on or after July 1, 1986 and before July 1, 1987 and is .50 thereafter without regard to the hospital's cost reporting period.

(4) Subject to the provisions of paragraph (i) of this section, for purposes of determining direct graduate medical education payment—

(i) For cost reporting periods beginning on or after October 1, 1997, a hospital's unweighted FTE count for residents in allopathic and osteopathic medicine may not exceed the hospital's unweighted FTE count (or, effective for cost reporting periods beginning on or after April 1, 2000, 130 percent of the unweighted FTE count for a hospital located in a rural area) for these residents for the most recent cost reporting period ending on or before December 31, 1996.

(ii) If a hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 1997, and before October 1, 2001, exceeds the limit described in this paragraph (g), the hospital's total weighted FTE count (before application of the limit) will be reduced in the same proportion that the number of FTE residents for that cost reporting period exceeds the number of FTE residents for the most re-

cent cost reporting period ending on or before December 31, 1996.

(iii) If the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this paragraph (g), the hospital's weighted FTE count (before application of the limit), for primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, will be reduced in the same proportion that the number of FTE residents for that cost reporting period exceeds the number of FTE residents for the most recent cost reporting period ending on or before December 31, 1996.

(iv) Hospitals that are part of the same Medicare GME affiliated group (as described under paragraph (b) of this section) may elect to apply the limit on an aggregate basis as described under paragraph (g)(7) of this section.

(v) The fiscal intermediary may make appropriate modifications to apply the provisions of this paragraph (g)(4) based on the equivalent of a 12-month cost reporting period.

(5) Subject to the provisions of paragraph (i) of this section, for purposes of determining direct graduate medical education payment—

(i) For the hospital's first cost reporting period beginning on or after October 1, 1997, the hospital's weighted FTE count is equal to the average of the weighted FTE count for the payment year cost reporting period and the preceding cost reporting period.

(ii) For cost reporting periods beginning on or after October 1, 1998, and before October 1, 2001, the hospital's weighted FTE count is equal to the average of the weighted FTE count for the payment year cost reporting period and the preceding two cost reporting periods.

(iii) For cost reporting periods beginning on or after October 1, 2001, the hospital's weighted FTE count for primary care and obstetrics and gynecology residents is equal to the average of the weighted primary care and obstetrics and gynecology counts for the payment year cost reporting period and the preceding two cost reporting periods, and the hospital's weighted FTE count for nonprimary care residents is

equal to the average of the weighted nonprimary care FTE counts for the payment year cost reporting period and the preceding two cost reporting periods.

(iv) The fiscal intermediary may make appropriate modifications to apply the provisions of this paragraph (g)(5) based on the equivalent of 12-month cost reporting periods.

(v) If a hospital qualifies for an adjustment to the limit established under paragraph (g)(4) of this section for new medical residency programs created under paragraph (g)(6) of this section, the count of the residents participating in new medical residency training programs above the number included in the hospital's FTE count for the cost reporting period ending during calendar year 1996 is added after applying the averaging rules in this paragraph (g)(5) for a period of years. Residents participating in new medical residency training programs are included in the hospital's FTE count before applying the averaging rules after the period of years has expired. For purposes of this paragraph (g)(5), for each new program started, the period of years equals the minimum accredited length for each new program. The period of years begins when the first resident begins training in each new program.

(vi) Subject to the regulations at paragraph (g)(9) of this section, FTE residents that are displaced by the closure of either another hospital or another hospital's program are added to the FTE count after applying the averaging rules in this paragraph (g)(5) for the receiving hospital for the duration of the time that the displaced residents are training at the receiving hospital.

(vii) Subject to the provisions under paragraph (g)(12) of this section, effective for cost reporting periods beginning on or after April 1, 2000, FTE residents in a rural track program at an urban hospital are included in the urban hospital's rolling average calculation described in paragraph (g)(5) of this section.

(6) If a hospital establishes a new medical residency training program as defined in paragraph (g)(13) of this section on or after January 1, 1995, the hospital's FTE cap described under

paragraph (g)(4) of this section may be adjusted as follows:

(i) If a hospital had no allopathic or osteopathic residents in its most recent cost reporting period ending on or before December 31, 1996, and it establishes a new medical residency training program on or after January 1, 1995, the hospital's unweighted FTE resident cap under paragraph (g)(4) of this section may be adjusted based on the product of the highest number of residents in any program year during the third year of the first program's existence for all new residency training programs and the number of years in which residents are expected to complete the program based on the minimum accredited length for the type of program. The adjustment to the cap may not exceed the number of accredited slots available to the hospital for the new program.

(A) If the residents are spending an entire program year (or years) at one hospital and the remainder of the program at another hospital, the adjustment to each respective hospital's cap is equal to the product of the highest number of residents in any program year during the third year of the first program's existence and the number of years the residents are training at each respective hospital.

(B) Prior to the implementation of the hospital's adjustment to its FTE cap beginning with the fourth year of the hospital's residency program(s), the hospital's cap may be adjusted during each of the first 3 years of the hospital's new residency program using the actual number of residents participating in the new program. The adjustment may not exceed the number of accredited slots available to the hospital for each program year.

(C) Except for rural hospitals, the cap will not be adjusted for new programs established more than 3 years after the first program begins training residents.

(D) An urban hospital that qualifies for an adjustment to its FTE cap under paragraph (g)(6)(i) of this section is not permitted to be part of a Medicare GME affiliated group for purposes of establishing an aggregate FTE cap.

(E) A rural hospital that qualifies for an adjustment to its FTE cap under paragraph (g)(6)(i) of this section is

permitted to be part of a Medicare GME affiliated group for purposes of establishing an aggregate FTE cap.

(ii) If a hospital had allopathic or osteopathic residents in its most recent cost reporting period ending on or before December 31, 1996, the hospital's unweighted FTE cap may be adjusted for new medical residency training programs established on or after January 1, 1995 and on or before August 5, 1997. The adjustment to the hospital's FTE resident limit for the new program is based on the product of the highest number of residents in any program year during the third year of the newly established program and the number of years in which residents are expected to complete each program based on the minimum accredited length for the type of program.

(A) If the residents are spending an entire program year (or years) at one hospital and the remainder of the program at another hospital, the adjustment to each respective hospital's cap is equal to the product of the highest number of residents in any program year during the third year of the first program's existence and the number of years the residents are training at each respective hospital.

(B) Prior to the implementation of the hospital's adjustment to its FTE cap beginning with the fourth year of the hospital's residency program, the hospital's cap may be adjusted during each of the first 3 years of the hospital's new residency program, using the actual number of residents in the new programs. The adjustment may not exceed the number of accredited slots available to the hospital for each program year.

(iii) If a hospital with allopathic or osteopathic residents in its most recent cost reporting period ending on or before December 31, 1996, is located in a rural area (or other hospitals located in rural areas that added residents under paragraph (g)(6)(i) of this section), the hospital's unweighted FTE limit may be adjusted in the same manner described in paragraph (g)(6)(ii) of this section to reflect the increase for residents in the new medical residency training programs established after August 5, 1997. For these hospitals, the limit will be adjusted for ad-

ditional new programs but not for expansions of existing or previously existing programs.

(iv) A hospital seeking an adjustment to the limit on its unweighted resident count policy must provide documentation to its fiscal intermediary justifying the adjustment.

(7) A hospital may receive a temporary adjustment to its FTE cap, which is subject to the averaging rules under paragraph (g)(5)(iii) of this section, to reflect residents added or subtracted because the hospital is participating in a Medicare GME affiliated group (as defined under paragraph (b) of this section). Under this provision—

(i) Each hospital in the Medicare GME affiliated group must submit the Medicare GME affiliation agreement, as defined under paragraph (b) of this section, to the CMS fiscal intermediary servicing the hospital and send a copy to CMS's Central Office no later than July 1 of the residency program year during which the Medicare GME affiliation agreement will be in effect.

(ii) Each hospital in the Medicare GME affiliated group must have a shared rotational arrangement, as defined in paragraph (b) of this section, with at least one other hospital within the Medicare GME affiliated group, and all of the hospitals within the Medicare GME affiliated group must be connected by a series of such shared rotational arrangements.

(iii) During the shared rotational arrangements under a Medicare GME affiliation agreement, as defined in paragraph (b) of this section, more than one of the hospitals in the Medicare GME affiliated group must count the proportionate amount of the time spent by the resident(s) in its FTE resident counts. No resident may be counted in the aggregate as more than one FTE.

(iv) The net effect of the adjustments (positive or negative) on the Medicare GME affiliated hospitals' aggregate FTE cap for each Medicare GME affiliation agreement must not exceed zero.

(v) If the Medicare GME affiliation agreement terminates for any reason, the FTE cap of each hospital in the Medicare GME affiliated group will revert to the individual hospital's pre-affiliation FTE cap that is determined

under the provisions of paragraph (g)(4) of this section.

(8) A hospital that began construction of its facility prior to August 5, 1997, and sponsored new medical residency training programs on or after January 1, 1995 and on or before August 5, 1997, that either received initial accreditation by the appropriate accrediting body or temporarily trained residents at another hospital(s) until the facility was completed, may receive an adjustment to its FTE cap.

(i) The newly constructed hospital's FTE cap is equal to the lesser of:

(A) The product of the highest number of residents in any program year during the third year of the newly established program and the number of years in which residents are expected to complete the programs based on the minimum accredited length for each type of program; or

(B) The number of accredited slots available to the hospital for each year of the programs.

(ii) If the new medical residency training programs sponsored by the newly constructed hospital have been in existence for 3 years or more by the time the residents begin training at the newly constructed hospital, the newly constructed hospital's cap will be based on the number of residents training in the third year of the programs begun at the temporary training site.

(iii) If the new medical residency training programs sponsored by the newly constructed hospital have been in existence for less than 3 years by the time the residents begin training at the newly constructed hospital, the newly constructed hospital's cap will be based on the number of residents training at the newly constructed hospital in the third year of the programs (including the years at the temporary training site).

(iv) A hospital that qualifies for an adjustment to its FTE cap under paragraph (g)(8) of this section may be part of an affiliated group for purposes of establishing an aggregate FTE cap.

(v) The provisions of this paragraph (g)(8) are applicable during portions of cost reporting periods occurring on or after October 1, 1999.

(9) *Closure of hospital or hospital residency program.*

(i) *Definitions.* For purposes of this paragraph (g)(9)—

(A) "Closure of a hospital" means the hospital terminates its Medicare agreement under the provisions of §489.52 of this chapter.

(B) "Closure of a hospital residency training program" means the hospital ceases to offer training for residents in a particular approved medical residency training program.

(ii) *Closure of a hospital.* A hospital may receive a temporary adjustment to its FTE cap to reflect residents added because of another hospital's closure if the hospital meets the following criteria:

(A) The hospital is training additional residents from a hospital that closed on or after July 1, 1996.

(B) No later than 60 days after the hospital begins to train the residents, the hospital submits a request to its fiscal intermediary for a temporary adjustment to its FTE cap, documents that the hospital is eligible for this temporary adjustment by identifying the residents who have come from the closed hospital and have caused the hospital to exceed its cap, and specifies the length of time the adjustment is needed.

(iii) *Closure of a hospital's residency training program.* If a hospital that closes its residency training program voluntarily agrees to temporarily reduce its FTE cap according to the criteria specified in paragraph (g)(9)(iii)(B) of this section, another hospital(s) may receive a temporary adjustment to its FTE cap to reflect residents added because of the closure of the residency training program if the criteria specified in paragraph (g)(9)(iii)(A) of this section are met.

(A) *Receiving hospital(s).* A hospital may receive a temporary adjustment to its FTE cap to reflect residents added because of the closure of another hospital's residency training program if—

(1) The hospital is training additional residents from the residency training program of a hospital that closed a program; and

(2) No later than 60 days after the hospital begins to train the residents,

the hospital submits to its fiscal intermediary a request for a temporary adjustment to its FTE cap, documents that it is eligible for this temporary adjustment by identifying the residents who have come from another hospital's closed program and have caused the hospital to exceed its cap, specifies the length of time the adjustment is needed, and submits to its fiscal intermediary a copy of the FTE reduction statement by the hospital that closed its program, as specified in paragraph (g)(9)(iii)(B)(2) of this section.

(B) *Hospital that closed its program(s).* A hospital that agrees to train residents who have been displaced by the closure of another hospital's program may receive a temporary FTE cap adjustment only if the hospital with the closed program—

(1) Temporarily reduces its FTE cap based on the FTE residents in each program year training in the program at the time of the program's closure. This yearly reduction in the FTE cap will be determined based on the number of those residents who would have been training in the program during that year had the program not closed; and

(2) No later than 60 days after the residents who were in the closed program begin training at another hospital, submit to its fiscal intermediary a statement signed and dated by its representative that specifies that it agrees to the temporary reduction in its FTE cap to allow the hospital training the displaced residents to obtain a temporary adjustment to its cap; identifies the residents who were in training at the time of the program's closure; identifies the hospitals to which the residents are transferring once the program closes; and specifies the reduction for the applicable program years.

(10) Effective for cost reporting periods beginning on or after November 29, 1999, a hospital may receive an adjustment to its FTE cap of up to three additional resident FTEs, if the hospital meets the following criteria:

(i) The additional residents are residents of a primary care program that would have been counted by the hospital as residents for purposes of the hospital's FTE cap but for the fact that the additional residents were on mater-

nity or disability leave or a similar approved leave of absence during the hospital's most recent cost reporting period ending on or before December 31, 1996;

(ii) The leave of absence was approved by the residency program director to allow the residents to be absent from the program and return to the program after the leave of absence; and

(iii) No later than 6 months after August 1, 2000, the hospital submits to the fiscal intermediary a request for an adjustment to its FTE cap, and provides contemporaneous documentation of the approval of the leave of absence by the residency director, specific to each additional resident that is to be counted for purposes of the adjustment.

(11) For cost reporting periods beginning on or after October 1, 1997, a non-Veterans Affairs (VA) hospital may receive a temporary adjustment to its FTE cap to reflect residents who had previously trained at a VA hospital and were subsequently transferred to the non-VA hospital, if that hospital meets the following criteria:

(i) The transferred residents had been training previously at a VA hospital in a program that would have lost its accreditation by the ACGME if the residents continued to train at the VA hospital;

(ii) The residents were transferred to the hospital from the VA hospital on or after January 1, 1997, and before July 31, 1998; and

(iii) The hospital submits a request to its fiscal intermediary for a temporary adjustment to its FTE cap, documents that it is eligible for this temporary adjustment by identifying the residents who have come from the VA hospital, and specifies the length of time those residents will be trained at the hospital.

(12) Subject to the provisions of (i) of this section, an urban hospital that establishes a new residency program, or has an existing residency program, with a rural track (or an integrated rural track) may include in its FTE count residents in those rural tracks, in addition to the residents subject to its FTE cap specified under paragraph (g)(4) of this section. An urban hospital with a rural track residency program may count residents in those rural

tracks up to a rural track FTE limitation if the hospital complies with the conditions specified in paragraphs (g)(12)(i) through (g)(12)(vi) of this section.

(i) If an urban hospital rotates residents to a separately accredited rural track program at a rural hospital(s) for two-thirds of the duration of the program for cost reporting periods beginning on or after April 1, 2000 and before October 1, 2003, or for more than one-half of the duration of the program for cost reporting periods beginning on or after October 1, 2003, the urban hospital may include those residents in its FTE count for the time the rural track residents spend at the urban hospital. The urban hospital may include in its FTE count those residents in the rural track training at the urban hospital, not to exceed its rural track FTE limitation, determined as follows:

(A) For the first 3 years of the rural track's existence, the rural track FTE limitation for each urban hospital will be the actual number of FTE residents, subject to the rolling average at paragraph (g)(5)(vii) of this section, training in the rural track at the urban hospital.

(B) Beginning with the fourth year of the rural track's existence, the rural track FTE limitation is equal to the product of the highest number of residents, in any program year, who during the third year of the rural track's existence are training in the rural track at the urban hospital or the rural hospital(s) and are designated at the beginning of their training to be rotated to the rural hospital(s) for at least two-thirds of the duration of the program for cost reporting periods beginning on or after April 1, 2000 and before October 1, 2002, or for more than one-half of the duration of the program effective for cost reporting periods beginning on or after October 1, 2003, and the number of years those residents are training at the urban hospital.

(ii) If an urban hospital rotates residents to a separately accredited rural track program at a rural nonhospital site(s) for two-thirds of the duration of the program for cost reporting periods beginning on or after April 1, 2000 and before October 1, 2003, or for more than one-half of the duration of the program

for cost reporting periods beginning on or after October 1, 2003, the urban hospital may include those residents in its FTE count, subject to the requirements under paragraph (f)(4) of this section. The urban hospital may include in its FTE count those residents in the rural track, not to exceed its rural track FTE limitation, determined as follows:

(A) For the first 3 years of the rural track's existence, the rural track FTE limitation for each urban hospital will be the actual number of FTE residents, subject to the rolling average specified in paragraph (g)(5)(vii) of this section, training in the rural track at the urban hospital and the rural nonhospital site(s).

(B) Beginning with the fourth year of the rural track's existence, the rural track FTE limitation is equal to the product of—

(1) The highest number of residents in any program year who, during the third year of the rural track's existence, are training in the rural track at—

(i) The urban hospital and are designated at the beginning of their training to be rotated to a rural nonhospital site(s) for at least two-thirds of the duration of the program for cost reporting periods beginning on or after April 1, 2000 and before October 1, 2003, or for more than one-half of the duration of the program for cost reporting periods beginning on or after October 1, 2003; and

(ii) The rural nonhospital site(s); and
(2) The number of years in which the residents are expected to complete each program based on the minimum accredited length for the type of program.

(iii) If an urban hospital rotates residents in the rural track program to a rural hospital(s) for less than two-thirds of the duration of the program for cost reporting periods beginning on or after April 1, 2000 and before October 1, 2003, or for one-half or less than one-half of the duration of the program for cost reporting periods beginning on or after October 1, 2003, the rural hospital may not include those residents in its FTE count (if the rural track is not a new program under paragraph (g)(6)(iii) of this section, or if the rural hospital's

FTE count exceeds that hospital's FTE cap), nor may the urban hospital include those residents when calculating its rural track FTE limitation.

(iv) If an urban hospital rotates residents in the rural track program to a rural nonhospital site(s) for period of time is less than two-thirds of the duration of the program for cost reporting periods beginning on or after April 1, 2000 and before October 1, 2003, or for one-half or less than one-half of the duration of the program for cost reporting periods beginning on or after October 1, 2003, the urban hospital may include those residents in its FTE count, subject to the requirements under paragraph (f)(4) of this section. The urban hospital may include in its FTE count those residents in the rural track, not to exceed its rural track limitation, determined as follows:

(A) For the first 3 years of the rural track's existence, the rural track FTE limitation for the urban hospital will be the actual number of FTE residents, subject to the rolling average specified in paragraph (g)(5)(vii) of this section, training in the rural track at the rural nonhospital site(s).

(B) Beginning with the fourth year of the rural track's existence, the rural track FTE limitation is equal to the product of—

(1) The highest number of residents in any program year who, during the third year of the rural track's existence, are training in the rural track at the rural nonhospital site(s) or are designated at the beginning of their training to be rotated to the rural nonhospital site(s) for a period that is less than two-thirds of the duration of the program for cost reporting periods beginning on or after April 1, 2002, and before October 1, 2003, or for one-half or less than one-half of the duration of the program for cost reporting periods beginning on or after October 1, 2003; and

(2) The length of time in which the residents are being training at the rural nonhospital site(s) only.

(v) All urban hospitals that wish to count FTE residents in rural tracks, not to exceed their respective rural track FTE limitation, must also comply with all of the following conditions:

(A) An urban hospital may not include in its rural track FTE limitation or (assuming the urban hospital's FTE count exceeds its FTE cap) FTE count residents who are training in a rural track residency program that were already included as part of the hospital's FTE cap.

(B) The hospital must base its count of residents in a rural track on written contemporaneous documentation that each resident enrolled in a rural track program at the hospital intends to rotate for a portion of the residency program to a rural area.

(C) All residents that are included by the hospital as part of its rural track FTE count (not to exceed its rural track FTE limitation) must train in the rural area. However, where a resident begins to train in the rural track program at the urban hospital but leaves the program before completing the total required portion of training in the rural area, the urban hospital may count the time the resident trained in the urban hospital if another resident fills the vacated FTE slot and completes the training in the rural portion of the rural track program. An urban hospital may not receive graduate medical education payment for the time the resident trained at the urban hospital if another resident fills the vacated FTE slot and first begins to train at the urban hospital.

(vi) If CMS finds that residents who are included by the urban hospital as part of its FTE count did not actually complete the training in the rural area, CMS will reopen the urban hospital's cost report within the 3-year reopening period as specified in § 405.1885 of this chapter and adjust the hospital's Medicare GME payments (and, where applicable, the hospital's rural track FTE limitation).

(13) For purposes of paragraph (g) of this section, a new medical residency training program means a medical residency that receives initial accreditation by the appropriate accrediting body or begins training residents on or after January 1, 1995.

(h) *Determination of weighting factors for foreign medical graduates.* (1) The weighting factor for a foreign medical

graduate is determined under the provisions of paragraph (g) of this section if the foreign medical graduate—

- (i) Has passed FMGEMS; or
- (ii) Before July 1, 1986, received certification from, or passed an examination of, the Educational Committee for Foreign Medical Graduates.

(2) Before July 1, 1986, the weighting factor for a foreign medical graduate is 1.0 times the weight determined under the provisions of paragraph (g) of this section. On or after July 1, 1986, and before July 1, 1987, the weighting factor for a graduate of a foreign medical school who was in a residency program both before and after July 1, 1986 but who does not meet the requirements set forth in paragraph (h)(1) of this section is .50 times the weight determined under the provisions of paragraph (g) of this section.

(3) On or after July 1, 1987, these foreign medical graduates are not counted in determining the number of FTE residents.

(4) During the cost reporting period in which a foreign medical graduate passes FMGEMS, the weighting factor for that resident is determined under the provisions of paragraph (g) of this section for the part of the cost reporting period beginning with the month the resident passes the test.

(5) On or after September 1, 1989, the National Board of Medical Examiners Examination, Parts I and II, may be substituted for FMGEMS for purposes of the determination made under paragraphs (h)(1) and (h)(4) of this section.

(6) On or after June 1, 1992, the United States Medical Licensing Examination may be substituted for the FMGEMS for purposes of the determination made under paragraphs (h)(1) and (h)(4) of this section. On or after July 1, 1993 only the results of steps I and II of the United States Medical Licensing Examination shall be accepted for purposes of making this determination.

(i) *Application of community support and redistribution of costs in determining FTE resident counts.* (1) For purposes of determining direct graduate medical education payments, the following principles apply:

- (i) *Community support.* If the community has undertaken to bear the costs

of medical education through community support, the costs are not considered graduate medical education costs to the hospital for purposes of Medicare payment.

(ii) *Redistribution of costs.* The costs of training residents that constitute a redistribution of costs from an educational institution to the hospital are not considered graduate medical education costs to the hospital for purposes of Medicare payment.

(2) *Application.* A hospital must continuously incur costs of direct graduate medical education of residents training in a particular program at a training site since the date the residents first began training in that program in order for the hospital to count the FTE residents in accordance with the provisions of paragraphs (f) and (g)(4) through (g)(6) and (g)(12) of this section. This rule also applies to providers that are paid for direct GME in accordance with §405.2468 of this chapter, §422.270 of this subchapter, and §413.70.

(3)(i) *Effective date.* Subject to the provisions of paragraph (i)(3)(ii) of this section, payments made in accordance with determinations made under the provisions of paragraphs (i)(1) and (i)(2) of this section will be effective for portions of cost reporting periods occurring on or after October 1, 2003.

(ii) *Applicability for certain hospitals.* With respect to an FTE resident who begins training in a residency program on or before October 1, 2003, and with respect to whom there has been a redistribution of costs or community support determined under the provisions of paragraphs (i)(1) and (i)(2) of this section, the hospital may continue to count the FTE resident until the resident has completed training in that program, or until 3 years after the date the resident began training in that program, whichever comes first.

(j) To include a resident in the FTE count for a particular cost reporting period, the hospital must furnish the following information.

The information must be certified by an official of the hospital and, if different, an official responsible for administering the residency program.

- (1) The name and social security number of the resident.

(2) The type of residency program in which the individual participates and the number of years the resident has completed in all types of residency programs.

(3) The dates the resident is assigned to the hospital and any hospital-based providers.

(4) The dates the resident is assigned to other hospitals, or other free-standing providers, and any nonprovider setting during the cost reporting period, if any.

(5) The name of the medical, osteopathic, dental, or podiatric school from which the resident graduated and the date of graduation.

(6) If the resident is an FMG, documentation concerning whether the resident has satisfied the requirements of paragraph (h) of this section.

(7) The name of the employer paying the resident's salary.

(k) *Special rules for States that formerly had a waiver from Medicare reimbursement principles.* (1) Effective for cost reporting periods beginning on or after January 1, 1986, hospitals in States that, prior to becoming subject to the prospective payment system, had a waiver for the operation of a State reimbursement control system under section 1886(c) of the Act, section 402 of the Social Security Amendments of 1967 (42 U.S.C. 1395b-1 or section 222(a) of the Social Security Amendment of 1972 (42 U.S.C. 1395b-1 (note))) are permitted to change the order in which they allocate administrative and general costs to the order specified in the instructions for the Medicare cost report.

(2) For hospitals making this election, the base-period costs for the purpose of determining the per resident amount are adjusted to take into account the change in the order by which they allocate administrative and general costs to interns and residents in approved program cost centers.

(3) Per resident amounts are determined for the base period and updated as described in paragraph (e) of this section. For cost reporting periods beginning on or after January 1, 1986, payment is made based on the methodology described in paragraph (d) of this section.

(l) *Adjustment of a hospital's target amount or prospective payment hospital-specific rate—(1) Misclassified operating costs—(i) General rule.* If a hospital has its base-period graduate medical education costs reduced under paragraph (e)(1) of this section because those costs included misclassified operating costs, the hospital may request that the intermediary review the classification of the affected costs in its rate-of-increase ceiling or prospective payment base year for purposes of adjusting the hospital's target amount or hospital-specific rate. For those cost reports that are not subject to reopening under § 405.1885 of this chapter, the hospital's reopening request must explicitly state that the review is limited to this one issue.

(ii) *Request for review.* The hospital must request review of the classification of its rate of increase ceiling or prospective payment base year costs no later than 180 days after the date of the notice by the intermediary of the hospital's base-period average per resident amount. A hospital's request for review must include sufficient documentation to demonstrate to the intermediary that adjustment of the hospital's hospital-specific rate or target amount is warranted.

(iii) *Effect of intermediary's review.* If the intermediary, upon review of the hospital's costs, determines that the hospital's hospital-specific rate or target amount should be adjusted, the adjustment of the hospital-specific rate or the target amount is effective for the hospital's cost reporting periods subject to the prospective payment system or the rate-of-increase ceiling that are still subject to reopening under § 405.1885 of this chapter.

(2) *Misclassification of graduate medical education costs—(i) General rule.* If costs that should have been classified as graduate medical education costs were treated as operating costs during both the graduate medical education base period and the rate-of-increase ceiling base year or prospective payment base year and the hospital wishes to receive benefit for the appropriate classification of these costs as graduate medical education costs in the graduate medical education base period, the hospital

must request that the intermediary review the classification of the affected costs in the rate-of-increase ceiling or prospective payment base year for purposes of adjusting the hospital's target amount or hospital-specific rate. For those cost reports that are not subject to reopening under § 405.1885 of this chapter, the hospital's reopening request must explicitly state that the review is limited to this one issue.

(ii) *Request for review.* The hospital must request review of the classification of its costs no later than 180 days after the date of the intermediary's notice of the hospital's base-period average per resident amount. A hospital's request for review must include sufficient documentation to demonstrate to the intermediary that modification of the adjustment of the hospital's hospital-specific rate or target amount is warranted.

(iii) *Effect of intermediary's review.* If the intermediary, upon review of the hospital's costs, determines that the hospital's hospital-specific rate or target amount should be adjusted, the adjustment of the hospital-specific rate and the adjustment of the target amount is effective for the hospital's cost reporting periods subject to the prospective payment system or the rate-of-increase ceiling that are still subject to reopening under § 405.1885 of this chapter.

[54 FR 40316, Sept. 29, 1989; 55 FR 290, Jan. 4, 1990, as amended at 56 FR 43243, Aug. 30, 1991; 57 FR 39830, Sept. 1, 1992; 58 FR 46343, Sept. 1, 1993; 59 FR 45401, Sept. 1, 1994; 60 FR 63189, Dec. 8, 1995; 61 FR 46225, Aug. 30, 1996; 62 FR 46034, Aug. 29, 1997; 63 FR 26358, May 12, 1998; 63 FR 41005, July 31, 1998; 64 FR 41542, July 30, 1999; 65 FR 47049, 47109, Aug. 1, 2000; 66 FR 32195, June 13, 2001; 66 FR 39932, 39937, Aug. 1, 2001; 67 FR 50119, Aug. 1, 2002; 68 FR 45471, Aug. 1, 2003; 68 FR 57733, Oct. 6, 2003]

§ 413.87 Payments for Medicare+Choice nursing and allied health education programs.

(a) *Statutory basis.* This section implements section 1886(l) of the Act, which provides for additional payments to hospitals that operate and receive Medicare reasonable cost reimbursement for approved nursing and allied health education programs and the methodology for determining the additional payments.

(b) *Scope.* This section sets forth the rules for determining an additional payment amount to hospitals that receive payments for the costs of operating approved nursing or allied health education programs under § 413.85.

(c) *Qualifying conditions for payment.*

(1) For portions of cost reporting periods occurring on or after January 1, 2000 and before January 1, 2001, a hospital that operates and receives payment for a nursing or allied health education program under § 413.85 may receive an additional payment amount associated with Medicare+Choice utilization. The hospital may receive the additional payment amount, which is calculated in accordance with the provisions of paragraph (d) of this section, if both of the conditions specified in paragraphs (c)(1)(i) and (c)(1)(ii) of this section are met.

(i) The hospital must have received Medicare reasonable cost payment for an approved nursing or allied health education program under § 413.85 in its cost reporting period(s) ending in the fiscal year that is 2 years prior to the current calendar year. (For example, if the current year is calendar year 2000, the fiscal year that is 2 years prior to calendar year 2000 is FY 1998.) For a hospital that first establishes a nursing or allied health education program after FY 1998 and receives reasonable cost payment for the program as specified under § 413.85 after FY 1998, the hospital is eligible to receive an additional payment amount in a calendar year that is 2 years after the respective fiscal year so long as the hospital also meets the condition under paragraph (c)(1)(ii) of this section.

(ii) The hospital must be receiving reasonable cost payment for an approved nursing or allied health education program under § 413.85 in the current calendar year.

(2) For portions of cost reporting periods occurring on or after January 1, 2001, in addition to meeting the conditions specified in paragraphs (c)(1)(i) and (c)(1)(ii) of this section, the hospital must have had a Medicare+Choice utilization greater than zero in its cost reporting period(s) ending in the fiscal year that is 2 years prior to the current calendar year.